

Charlotte Hungerford Hospital  
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Approved  
9/26/18  
SHN

September 21, 2018

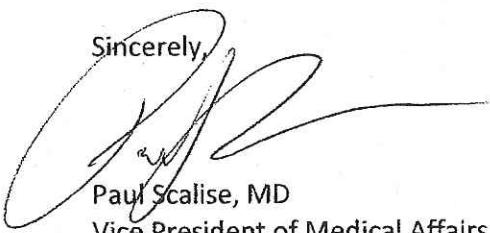
Susan H. Newton, RN, BS  
Supervising Nurse Consultant  
Department of Public Health  
Facility Licensing Investigation Section  
410 Capitol Avenue, MS #12 FLIS  
P.O. Box 340308  
Hartford, CT 06134-0308

Dear. Ms. Newton:

Enclosed please find the Charlotte Hungerford Hospital's response to the letter of violation dated September 10, 2018.

Should you have any questions or require additional information, I can be reached at 860-496-6611 or at [pscalise@hhchealth.org](mailto:pscalise@hhchealth.org). Kate Betancourt, Director of Quality, can be reached at 860-496-6347 or at [kbetancourt@hchhealth.org](mailto:kbetancourt@hchhealth.org).

Sincerely,

  
Paul Scalise, MD  
Vice President of Medical Affairs

**Charlotte Hungerford Hospital**  
**Plan of Correction for**  
**Violation Letter Dated September 10, 2018**

Tag/Violation	Defined Measures to Prevent Reoccurrence	Completion Date
<p><b>Violation # 1a:</b>  The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Service (1) and or General (6).</p> <p>*Based on a clinical record review, facility documentation and interviews for one of three sampled patients receiving oxygen in the ED, the hospital failed to ensure that a portable oxygen tank had a sufficient amount of oxygen for patient use resulting in a change in the patient's oxygen saturation level requiring intubation.</p>	<p><b>Responsible person:</b>  Vice President of Patient Care Services</p> <p><b>Action Items/Implementation Plan:</b></p> <p><b>Immediate Actions:</b></p> <ol style="list-style-type: none"> <li>1. On 7/23/18, communication was sent by the Administrative Director of Nursing to all Emergency Department RNs reinforcing that when administering oxygen via a portable tank to patients in the Emergency Department: <ol style="list-style-type: none"> <li>a. Always utilize a new, full tank</li> <li>b. Admit patient to a treatment room as soon as possible</li> <li>c. Reassess oxygen tank status frequently</li> </ol> </li> <li>2. On 7/24/18, Interim Guidelines for Use of Portable Oxygen Tanks in the Emergency Room Department were developed, with a mandatory acknowledgement/sign-off required.</li> <li>3. On 7/25/18, the identified issue was reviewed at the Quality Assessment and Performance Improvement Committee meeting.</li> <li>4. On 7/31/18 during the organizational daily safety huddle, a Safety Alert re: monitoring oxygen tank status was reviewed with all leaders in attendance.</li> <li>5. On 7/31/18, an email was sent to clinical leadership with a written safety alert on oxygen tank monitoring, as well as hospital policy for transporting patients with oxygen, for review and forwarding to their teams. The alert included a job aide to assist clinical staff in gauging the length of time an oxygen tank will last, based on delivery flow rate.</li> <li>6. On 8/1/18, hard copies of the Safety Alert were provided to leadership during daily safety huddle with instructions to review the alert during unit-based huddles and to post in staff areas.</li> <li>7. On 8/6/18 the identified issue was reviewed at the Medical Executive Committee.</li> </ol> <p><b>Additional Actions:</b></p> <ol style="list-style-type: none"> <li>1. Policy # 100.016, Transporting Patients with Oxygen, will be updated to include expectations regarding verification and monitoring of tank status.</li> <li>2. On 9/26/18, the identified issue will be reviewed at the Board of Directors meeting.</li> </ol>	7/23/18 7/24/18 7/25/18 7/31/18 7/31/18 8/1/18 8/6/18 9/21/18 9/26/18

Tag/Violation	Defined Measures to Prevent Reoccurrence	Completion Date
	<p><b>Ongoing Monitoring Plan:</b></p> <ol style="list-style-type: none"> <li>1. Starting in October 2018, 5 random weekly audits will be conducted by the Respiratory Therapy team to confirm that:             <ol style="list-style-type: none"> <li>a. Oxygen tank storage is consistent with policy (proper segregation of full/post use oxygen tanks)</li> <li>b. Oxygen tank status is adequate for patient need and being monitored by personnel when in use.</li> </ol> </li> <li>2. Weekly audits will continue until 4 consecutive weeks demonstrate 100% compliance on both parameters. Thereafter, quarterly audits will be conducted x two to confirm that performance is sustained.</li> </ol> <p><b>Where Reported:</b></p> <ol style="list-style-type: none"> <li>1. Results will be reported out at the QAPIC meetings until auditing concludes.</li> </ol>	Ongoing
<p><b>Violation # 2a:</b></p> <p>The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3(b) Administration (2).</p> <p>Based on a clinical record review, facility documentation and interviews for one of three patients reviewed for grievances, the facility failed to ensure efforts were made to provide a resolution.</p>	<p><b>Responsible person:</b></p> <p>Director of Patient Experience</p> <p><b>Action Items/Implementation Plan:</b></p> <p><b>Immediate Actions:</b></p> <ol style="list-style-type: none"> <li>1. On 5/25/18, the Director of Patient Experience met with staff and reviewed expectations to provide an interim update or to close grievances regardless of pending communication from the patient or his/her representative.</li> <li>2. On 7/23/18, the preliminary finding from DPH related to delayed closure of a grievance was reported to the QAPIC and recommendation was made to report metrics on timely grievance closure to QAPIC on a monthly basis.</li> <li>3. As of 8/22/18, the metric "percent of grievances closed within 30days" was added to the standing regulatory report.</li> </ol> <p><b>Additional Actions:</b></p> <ol style="list-style-type: none"> <li>1. Starting the week of 9/24/18, a weekly review process will be initiated to confirm closure (or interim communication) on any grievance due for closure within the subsequent 7 days. A tracking log will be utilized to capture the review process.</li> </ol>	Ongoing

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	<p><b>Monitoring:</b></p> <ol style="list-style-type: none"> <li>1. Monthly review of percent grievances closed within 30 days will be continued until 3 consecutive months of <math>\geq 100\%</math> compliance has been sustained. Thereafter,</li> <li>2. Quarterly audits will be performed and reported to QAPIC.</li> </ol> <p><b>Where reported:</b></p> <ol style="list-style-type: none"> <li>1. CHH QAPIC, minutes of which are submitted to the Northwest Regional Board of Directors</li> <li>2. CHH Grievance Committee</li> </ol>	Ongoing